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ABSTRACT

The study attempted to determine whether monolingual English-speaking supervisors and bilingual-bicultural supervisors would provide markedly different supervision management to bilingual (English-Spanish) student clinicians in audiology/speech pathology. After viewing each of 10 video-tapes of Spanish language therapy sessions for 2 preschool bilingual females, 2 bilingual and 2 monolingual supervision judges rated the clients' and the clinicians' cognitive, linguistic, and social components of communication and suggested the next step in the supervision of the clinician. The result of a chi square analysis showed no statistically significant differences in the way bilingual and monolingual clinical supervisors judged the clinicians' or the clients' behavior, in the types of supervisory decisions they made, or in individual supervisor judgments. The predominant supervisory strategy of conferring with the clinician confirmed conferences as critical to the supervisory process. Because of the small sample size, results should be viewed with caution. Further studies are suggested to determine whether bilingual/bicultural sensitivity training and critical skill training can make a difference in supervision and to examine the emphasis to be placed on the linguistic components of communication, the amount of oral language used in therapy, and the effect of tasks on supervisors' judgments. (SB)

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BILINGUAL SUPERVISION: DOES IT MAKE A DIFFERENCE?

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BILINGUAL SUPERVISION: DOES IT MAKE A DIFFERENCE?

INTRODUCTION

According to the United States Census Bureau, individuals with Spanish-language background comprise one of the fastest growing segments of the American population. Currently 8% of the handicapped population, or more than 125,000 children nationwide, are Spanish-English bilinguals. Of the children identified as speech-handicapped only, 23.8% are Hispanic. This percentage increases when children are included whose primary handicap is other than speech-impaired, but who require speech-language pathology/audiology services.

The American Speech-Language-Hearing Association (ASHA) has recently increased its efforts to address the issue of communicative disorders in bilingualism by developing the Bilingual Language Learning System (BLLS), a federally funded project designed to develop and implement training procedures and materials that target issues in bilingual/bicultural communication assessment and treatment for Hispanic children with suspected speech, language, or hearing disorders. The BLLS training manual states that the most qualified professional to work with the bilingual (or monolingual Spanish) child would be a bilingual/bicultural speech-language pathologist and audiologist. In addition to these professionals receiving specific bilingual-bicultural education and training, the guidelines recommend that:

> Bilingual students need to be supervised by bilingual speech-language pathologists or audiologists in order to insure comprehensive assessments and to maximize the students' learning as future professionals. Bilingual supervisors are preferable to monolingual supervisors because they can more fully comprehend the assessment process and can provide insight and input into the total evaluation procedure. Feedback from the bilingual supervisors is critical, for once the students graduate, they frequently are the only bilingual-bicultural speech-language pathologists or audiologists within their work settings and communities. The bilingual students must demand from the bilingual/bicultural supervisors maximum supervision and academic

guidance to insure breadth of knowledge and mastery of skill in effectively managing the minority-speaking speech-language and hearing disordered population.

With the dearth of bilingual-bicultural speech-language pathologists and audiologists in the profession, it is reasonable to assume that bilingual student clinicians cannot always be supervised by a bilingual-bicultural supervisor, especially one who is trained in the supervisory process. However, if supervision is not provided by a bilingual-bicultural supervisor, but instead by a monolingual English-speaking supervisor, would supervision management decisions be markedly different? If so, in what domains would they differ? In order to explore these questions, the following study was developed.

METHOD AND PROCEDURE

Biweekly, individual language therapy sessions involving two language disordered (at least 2 years below their chronological age in receptive and expressive abilities in both languages) bilingual (Spanish-English) preschool females ("S":CA = 5-1; "Y":CA = 4-7) were videotaped. Therapy sessions were conducted in Spanish by bilingual clinicians and supervised by a bilingual clinical supervisor. Client "S" had one male and one female clinician; client "Y" had one female clinician. Therapy goals for each child were to increase proficiency in the cognitive, linguistic, and/or social components of her L1 (Spanish). From the 14 weeks of therapy, 10 segments were selected to be judged by four clinical supervisor-judges (two monolingual-English, two bilingual Hispanic). Following is a list of the 10 videotaped segments with the terminal behavior (TB) and task defined for each.

Segment 1. Client "S"
TB: To familiarize "S" with the sound of the /p/ phoneme.
Task: Picture cards with /p/ in the initial position will be utilized to emphasize the sound.

Segment 2. Client "Y"
TB: To expose "Y" to Reactive/Interactive therapy techniques and to shape her verbal responses for requesting object to "da-me" (give me).
Task: During play with blocks, Clinician will, in Spanish, use R/I techniques and withhold object until client verbally requests with "da-me."

Segment 3. Client "S"
TB: Increase "S"'s verbalizations.
Task: Color Easter eggs.

Segment 4. Client "S"
TB: Improve production of /p/ sound.
Task: Present picture cards with /p/ in initial position.

Segment 5. Client "Y"
TB: She will, when requested, place a red object on a red piece of paper.
Task: When presented with a red object and the command to place it on the red paper, "Y" will follow through.

Segment 6. Client "S"
TB: Verbalize body parts when pointed to.
Task: Body parts will be pointed to and "S" will be asked to label this body part.

Segment 7. Client "Y"
TB: To provide an opportunity for "Y" to exhibit fine motor movement and to expose her to R/I therapy techniques.
Task: While sitting at the table, "Y" will participate in playing with clay.

Segment 8. Client "S"
TB: Increase "S"'s spontaneous verbalizations.
Task: Use large blocks.

Segment 9. Client "S"
TB: To increase "S"'s verbalizations.
Task: A game of "Match-Ups" will be utilized.

Segment 10. Client "Y"
TB: She will be exposed to the clinician reading and required to point to rabbit, shoe, and bird.
Task: While sitting on the Clinician's lap, "Y" will attend to the reading of a book and will point to requested pictures.

The supervisor-judges rated client behaviors, clinician behaviors, and client-clinician interactions which were categorized into cognitve, linguistic, and social components of communication. After each task was rated, the supervisor-judges indicated what their next step in the supervisory process would be.

JUDGES

All four supervisor-judges (B1, B2, M3, M4) had been trained in the supervisory process by having completed the graduate level seminar in clinical supervision at NMSU (CD 590), or by having had equivalent education and experience in the supervisory process. The years of supervision involvement were: B1 = 3 years; B2 = 4 years; M3 = 2 years; M4 = 12 years.

FORMS

Each of the supervisor-judges used the Bilingual Supervision Judging Form (BSJF) (Appendix) to judge clinician and client communication behaviors and to make decisions about subsequent supervision management. On Section I of the BSJF, a 7 point scale was utilized to rate clinician behaviors (26 items) from "poor, failing, not acceptable" (1) to "exceptional, excellent, superior" (5); Not Applicable (6); Don't Know, Can't Tell (7). On Section II, client behaviors (25 items) were rated on a frequency of occurrence scale from "never occurred" (1) to "always occurred" (5); Not Applicable (6); Don't Know, Can't Tell (7). All clinician and client behaviors were designated as cognitive, linguistic, or social components of communication. The cognitive components of the clinician's communication included any therapy techniques (e.g., "used nonverbal cues to facilitate verbal communication"); cognitive components of the client's communication involved any cognitive processes or learning strategies employed by the client (e.g., "responded to verbal reinforcement"). Linguistic

components of the clinicians' and the clients' communication included phonologic, semantic, and syntactic aspects of their verbalizations. Social components of the clinicians' and the clients' communication included pragmatic and interpersonal features. On Section III, the supervisor-judges indicated their next step in the supervisory process as if they had been supervising the therapy task they had just viewed. Their choices were to:

1. Meet with the clinicians to:
   a. Get more information from the clinicians about the task.
   b. Discuss continuing the task as it is set up to attain a specific objective.
   c. Discuss continuing the task but with modifications (specify).
   d. Discuss discontinuing the task.
   e. Other (specify).

2. Provide written feedback to the clinicians suggesting:
   a. That the clinicians provide the supervisor with more information through written form.
   b. Continuing the task as it is set up.
   c. Continuing the task but with modifications (specify).
   d. Discontinuing the task.
   e. Other (specify)

3. Do demonstration therapy

4. Do nothing

5. Other (specify)

PROCESS

Each supervisor-judge, following standardized instructions, viewed the 10 videotaped therapy segments individually and in a random order. After viewing each segment, the supervisor-judge completed a BSJF in total and then proceeded to the next videotape segment in their randomization. Supervisor-judges were allowed to re-view any segment at their discretion. Average viewing time for the four supervisor-judges was approximately 4 hours. From critical observation skill training in the supervision seminar, the supervisor-judges had achieved reliability scores of between .85 and .90 when observing language therapy sessions from videotape.

RESULTS

In order to determine if significant differences existed in the judgments of monolingual and bilingual clinical supervisors, all data were analyzed using the Chi-square goodness of fit test for homogeneity. Results of the Chi-square procedure showed no statistically significant differences in the way bilingual (B1 and B2) and monolingual (M3 and M4) clinical supervisors judged the clinicians' behavior, the clients' behavior, or in the types of supervisory process decisions that they made. Additionally, no statistically significant differences in individual supervisor (B1 vs. B2 vs. M3 vs. M4) judgments were evident. However, because of the small sample, these results must be interpreted with caution. Therefore, the data are further interpreted with regard to trends that emerged from the mean scores of the various ratings. For ease of analysis, the mean scores were compared to grouped scores on the 7 point scale, i.e., 1 & 2 = Below Average (BA); 3 = Average (A); 4 & 5 = Above Average (AA).

CLINICIANS

1. The mean ratings of the clinician items by the bilingual supervisor-judges (BSJ) were slightly higher than the ratings of the monolingual supervisor-judges (MSJ) for 8 of the 10 videotaped segments; 7 of the 8 segments were 1 level higher, 1 of the 8 segments was 2 levels higher (Table 1).
2. The MSJ used more "Don't Know; Can't Tell" responses than the BSJ in 6 of the 10 videotaped segments (Table 1).
3. Across segments, the MSJ used more "Don't Know; Can't Tell" total responses (19) than the BSJ (14) (Table 1).
4. Mean ratings by the BSJ and the MSJ of the two clinicians treating client "S" were higher than the mean ratings of the clinician treating client "Y" (Table 1).

Table 1

Grouped Overall Mean Scores of 26 Clinician Items for 10 Videotaped Segments by Supervisor-Judge Language (Monolingual or Bilingual)

Segment	Client	Score/Grouped Ranking/Level Difference B	Score/Grouped Ranking/Level Difference M		Don't Know Category B	Don't Know Category M
1	"S"	3.9 A	3.[illegible] A	(S)	0	1
3	"S"	4.4 AA	3.0 A	(1)	0	1
4	"S"	4.2 AA	3.4 A	(1)	2	1
6	"S"	3.8 A	3.2 A	(S)	0	2
8	"S"	4.3 AA	3.9 A	(1)	0	1
9	"S"	4.2 AA	3.3 A	(1)	3	3
	Mean	4.1 AA	3.4 A	(1)	Subtotal 5	9
2	"Y"	3.3 A	1.7 BA	(1)	1	3
5	"Y"	3.9 A	2.7 BA	(1)	0	3
7	"Y"	3.9 A	2.0 BA	(1)	1	1
10	"Y"	4.0	2.6	(2)	7	3
	Mean	3.8 A	2.3 BA	(1)	Subtotal 9	10
					Total 14	19

*1 & 2 = Below Average (BA); 3 = Average (A); 4 & 5 = Above Average (AA)
(S) = Same level
(1) = 1 level difference
(2) = 2 level difference

CLIENTS

1. The mean ratings of client items by the BSJ were higher in only 1 of the 10 videotaped segments (2 level difference); ratings of the other 9 segments were equal (Table 2).
2. The BSJ used more "Don't Know, Can't Tell" responses than the MSJ in 3 of the 10 videotaped segments; the MSJ used more "Don't Know, Can't Tell" responses than the BSJ in 5 of the 10 videotaped segments; ratings of the remaining 2 segments were equal (Table 2).
3. Across segments, the BSJ used more "Don't Know, Can't Tell" total responses (28) than the MSJ (25) (Table 2).
4. Both the MSJ and the BSJ rated the items of client "S" higher than the items of client "Y" (Table 2).

SUPERVISION MANAGEMENT

1. The MSJ preferred management strategy was "to meet with clinicians to get more information about the task."
2. The BSJ preferred management strategy was "to meet with clinicians to discuss continuing the task but with modifications."
3. The MSJ preferred strategy and the BSJ preferred strategy were the two most preferred strategies, respectively.
4. The MSJ least preferred strategy was "to provide written feedback to the clinicians suggesting continuing the task as it is set up."
5. The BSJ least preferred strategy was "to provide written feedback to the clinicians suggesting discontinuing the task."
6. Not one of the judges chose "do nothing" as a possible strategy for any of the videotaped segments.
7. Both the BSJ and the MSJ chose Segment 2 (Client "Y" doing the"da-me" drill) as needing the most supervision management.

8. The BSJ indicated that they would use more supervision management strategies for client "S" than for client "Y."
9. The MSJ indicated that they would use more supervision management strategies for client "Y" than for client "S."

Table 2

Grouped Overall Mean Scores of 25 Client Items for 10 Videotaped Segments by Supervisor-Judge Language (Bilingual or Monolingual)

Segment/Client		Score/Grouped Ranking/Level Difference B	M		Don't Know Category B	M
1	"S"	3.3 A	3.5 A	(S)	4	4
3	"S"	3.5 A	3.1 A	(S)	2	3
4	"S"	3.6 A	3.6 A	(S)	3	3
6	"S"	3.3 A	3.6 A	(S)	1	2
8	"S"	3.5 A	3.8 A	(S)	1	2
9	"S"	3.7 A	3.4 A	(S)	1	2
	Mean	3.5 A	3.5 A	(S)	Subtotal 12	16
2	"Y"	2.3 BA	2.1 BA	(S)	2	3
5	"Y"	2.6 BA	2.3 BA	(S)	4	2
7	"Y"	3.1 AA	1.8 BA	(2)	3	1
10	"Y"	2.8 BA	2.1 BA	(S)	7	3
	Mean	2.7 BA	2.1 BA	(S)	Subtotal 16	9
					Total 28	25

*1 & 2 = BA; 3 = A; 4 & 5 = AA
(S) = Same level
(1) = 1 level difference
(2) = 2 level difference

COMMUNICATION COMPONENTS--Clinicians

The grouped rankings (i.e., 1 & 2 = BA; 3 = A; 4 & 5 = AA) of the mean ratings of the 26 clinician items were found to show the following trends:

1. Of the 26 clinician items that were judged, the BSJ mean ratings for 24 items grouped 1 or 2 levels higher than the MSJ mean ratings; the mean ratings for 2 items grouped equally for the BSJ and the MSJ (Table 3).
2. Six of the 26 clinician items were categorically linguistic components of communication. Of the 6 linguistic items rated across the 10 videotaped segments, mean ratings of the BSJ for 3 items (50%) grouped 2 levels higher than the MSJ mean ratings (Table 3).
3. Thirteen of the 26 clinician items were categorically cognitive components of communication. Of the 13 cognitive items rated across the 10 videotaped segments, mean ratings of the BSJ for 4 items (31%) grouped 2 levels higher than the MSJ mean ratings (Table 3).
4. Seven of the 26 clinician items were categorically social components of communication. Of the 7 social items rated across the 10 videotaped segments, mean ratings of the BSJ for 1 behavior (14%) grouped 2 levels higher than the MSJ mean ratings (Table 3).

Table 3

Grouped Mean Scores of 26 Clinician Items for Cognitive, Linguistic, and Social Components of Communication by Supervisor-Judge Language (Monolingual or Bilingual)

COGNITIVE Components (13) (Item)	Score/Grouped Ranking/Level Difference B	M	*
2	4.1	3.6	
	AA	A	(1)
11	4.1	3.0	
	AA	A	(1)
12	4.0	3.3	
	AA	A	(1)
14	3.3	2.9	
	A	BA	(1)
15	4.0	2.7	
	AA	BA	(2)
18	4.3	2.8	
	AA	BA	(2)
19	4.1	3.1	
	AA	A	(1)
20	3.8	3.2	
	A	A	(S)
21	4.1	2.9	
	AA	BA	(2)
23	2.9	2.3	
	BA	BA	(S)
24	3.5	2.2	
	A	BA	(1)
25	4.0	2.5	
	AA	BA	(2)
26	3.8	2.3	
	A	BA	(1)
SOCIAL Components (7)			
1	4.1	3.3	
	AA	A	(1)
3	4.1	3.4	
	AA	A	(1)
5	4.2	3.3	
	AA	A	(1)
6	4.3	3.2	
	AA	A	(1)
7	4.2	3.1	
	AA	A	(1)
8	2.7	3.0	
	BA	A	(1)
9	4.1	2.9	
	AA	BA	(2)

Table 3 (Con't)

LINGUISTIC Components (6)	B	M	
4	3.8	2.9	
	A	BA	(1)
10	4.3	2.9	
	AA	BA	(2)
13	4.0	2.9	
	AA	BA	(2)
16	3.6	2.7	
	A	BA	(1)
17	4.1	2.7	
	AA	BA	(2)
22	3.4	2.9	
	A	BA	(1)

*1 & 2 = BA; 3 = A; 4 & 5 = AA
(S) = Same level
(1) = 1 level difference
(2) = 2 level difference

COMMUNICATION COMPONENTS--Client

The grouped rankings (i.e., 1 & 2 = BA; 3 = A; 4 & 5 = AA) of the mean ratings for the 25 client items were found to show the following trends:

1. Of the 25 client items that were judged, the BSJ mean ratings for 11 items grouped 1 level higher than the MSJ mean ratings; the MSJ mean ratings for 2 items grouped 1 level higher than the BSJ mean ratings; the mean ratings for 12 items grouped equally for the BSJ and the MSJ (Table 4).
2. Thirteen of the 25 client items were categorically social components of communication. Of the 13 social items rated across the 10 videotaped segments, mean ratings of the BSJ for 7 items (54%) grouped 1 level higher than the MSJ mean ratings; mean ratings of the MSJ for 1 item (8%) grouped 1 level higher that the BSJ ratings. Therefore, the mean ratings of the 13 social items showed a 1 level difference between the BSJ and the MSJ for a total of 8 items (62%) (Table 4).
3. Eight of the 25 client items were categorically cognitive components of communication. Of the 8 cognitive items rated across the 10 videotaped segments, mean ratings of the BSJ for 3 items (38%) grouped 1 level higher than the MSJ mean ratings; MSJ mean ratings for 1 item (12%) grouped 1 level higher than the BSJ mean ratings. Therefore, the mean ratings of the 8 cognitive items showed a 1 level difference between the BSJ and the MSJ for a total of 4 items (50%) (Table 4).
4. Four of the 25 client items were categorically linguistic components of communication. Of the 4 linguistic items rated across the 10 videotaped segments, the BSJ mean ratings for 1 item (25%) grouped 1 level higher than the MSJ mean ratings; the mean ratings for the other 3 linguistic items groups equally for the BSJ and the MSJ (Table 4).

Table 4

Grouped Scores of 25 Client Items for Cognitive, Linguistic, and Social Components of Communication by Supervisor-Judge Language (Monolingual or Bilingual)

LINGUISTIC Components (4) (Item)	Score/Grouped Ranking/Level Difference B	M	*
42	3.1	2.8	
	A	BA	(1)
48	1.2	2.0	
	BA	BA	(S)
49	1.2	1.5	
	BA	BA	(S)
51	1.9	2.6	
	BA	BA	(S)
SOCIAL Components (13)			
27	3.9	3.0	
	A	A	(S)
29	4.3	3.4	
	AA	A	(1)
30	4.1	3.7	
	AA	A	(1)
32	4.4	3.2	
	AA	A	(1)
33	2.5	2.6	
	A	A	(S)
34	3.6	3.6	
	A	A	(S)
35	3.5	2.6	
	A	BA	(1)
36	3.0	2.6	
	A	BA	(1)
37	2.9	3.1	
	BA	A	(1)
43	4.2	3.4	
	AA	A	(1)
44	1.9	2.4	
	BA	BA	(S)
46	3.1	2.9	
	A	BA	(1)
47	1.5	2.5	
	BA	BA	(S)

Table 4 (Con't)

COGNITIVE Components (8)	B	M	
28	4.2 AA	3.2 A	(1)
31	3.8 A	3.4 A	(S)
38	3.7 A	3.1 A	(S)
39	3.4 A	2.9 BA	(1)
40	3.5 A	3.1 A	(S)
41	3.1 A	2.7 BA	(1)
45	2.8 BA	2.9 BA	(S)
50	2.8 A	3.4 BA	(1)

*1 & 2 = BA; 3 = A; 4 & 5 = AA
(S) = Same level
(1) = 1 level difference
(2) = 2 level difference

ITEM ANALYSIS

Clinician Items

The specific clinician items (COGNITIVE Category) judged differently by the two groups of supervisor-judges by either 1 grouped level (1) or 2 grouped levels (2) include:

Item	Description	Level of Difference
2	...was attentive	(1)
11	...responded to nonverbal cues	(1)
12	...used appropriate positioning	(1)
14	...used nonverbal reinforcement	(1)
15	...used nonverbal to facilitate comprehension	(2)
18	...recorded data	(2)
19	...used materials approp. to client's needs/interests	(1)
21	...managed behavior appropriately	(2)
24	...modifies inappropriate behavior in self	(1)
25	...used appropriate pace	(2)
26	...used time efficiently	(1)

The specific clinician items (SOCIAL Category) judged differently by the two groups of supervisor-judges by either 1 grouped level (1) or 2 grouped levels (2) include:

Item	Description	Level of Difference
1	...was confident	(1)
3	...was comfortable	(1)
5	...was enthusiastic	(1)
6	...was enjoying the task	(1)
7	...was the dominant person	(1)
8	...was the non-dominant person	(1)
9	...was an equal participant	(2)

The specific clinician items (LINGUISTIC Category) judged differently by the 2 groups of supervisor-judges by either 1 grouped level (1) or 2 grouped levels (2) include:

Item	Description	Level of Difference
4	...was comprehending the client	(1)
10	...responded to verbal cues	(2)
13	...used verbal reinforcement	(2)
16	...judged responses accurately	(1)
17	...reacted approp. to client's communication attempts	(2)
22	...served as an appropriate communication model	(1)

Client Items

The specific client items (SOCIAL Category) judged differently by the 2 groups of supervisor-judges by 1 grouped level (1) include:

Item	Description	Level of Difference
29	...was comfortable	(1)
30	...was enthusiastic	(1)
32	...was enjoying the task	(1)
35	...was an equal partner	(1)
36	...initiated interaction	(1)
37	...demonstrated turn-taking	(1)
43	...was cooperative	(1)
46	...demonstrated age-appropriate social development	(1)

The specific client items (COGNITIVE Category) judged differently by the 2 groups of supervisor-judges by 1 grouped level (1) include:

Item	Description	Level of Difference
28	...was attentive	(1)
39	...responded to nonverbal cues	(1)
41	...responded to nonverbal reinforcement	(1)
50	...demonstrated age-appropriate motor skills	(1)

The specific client item (LINGUISTIC Category) judged differently by the 2 groups of supervisor-judges by 1 grouped level was:

Item	Description	Level of Difference
42	...produced correct responses	(1)

DISCUSSION/IMPLICATIONS

Although formal statistical analysis showed no significant differences in the ratings of clinician items, client items, or supervision management decisions by bilingual and monolingual supervisor-judges either as groups or as individuals, the statistical data must be interpreted with caution because of the small sample size. However, the study can be discussed productively by drawing tentative implications and suggesting further research efforts within two areas: 1) Bilingual issues and, 2) Supervision issues.

BILINGUAL ISSUES

The results of the present study can be discussed with respect to bilingualism from three perspectives: 1) the effect of the amount of oral language that is used by the clinicians and the clients; 2) the relative importance of the linguistic components in communicative competence, and 3) the effect that particular tasks have on a monolingual-English supervisor's ability to make judgments about therapy that is being done in another language.

In order to understand the complexity of communicative disorders in bilingual/bicultural populations, the concept of communicative competence must be used, i.e., emphasis must be placed not only on specific linguistic (phonologic, semantic, syntactic) components of languages, but also on cognitive and social components. The communicative competence perspective allows for viewing communication as a transactive process and addressing the nonverbal as well as the verbal dimensions of the communication process. When this view of the communication process is taken, it is less likely to be assumed that monolingual supervisors cannot provide quality supervision for bilingual client/clinician interactions because they "don't understand or speak the language." A significant amount of communication can be comprehended by critically observing the cognitive and social (including nonverbal) dimensions

of communication. Therefore, having native or near native facility in a languge may not be as critical as the BLLS committee suggests.

On the other hand, the greater differences between monolingual supervisor-judges (MSJ) and bilingual supervisor-judges (BSJ) in ratings of the linguistic components of the clinicians' communication may suggest that if more oral language is involved in the communication acts, it will be more difficult for a monolingual supervisor to make accurate judgments about the linguistic components of communication. In all 10 videtaped segments, the clinicians used more oral language than the clients. However, to explore the complexity of this idea, discussion about the frequency of use of the "Don't Know, Can't Tell" category is germane. The number of "Don't Know, Can't Tell" responses is different for the MSJ and the BSJ for the judgments made about the clinicians and the clients. That is, the MSJ used slightly more "Don't Know, Can't Tell" responses than the BSJ when judging the clinician items but the BSJ used slightly more "Don't Know, Can't Tell" responses than the MSJ when judging client items. If the assumption is made that the "Don't Know, Can't Tell" category was used most often to indicate that the instances of oral language "weren't understood" then perhaps the MSJ could not understand the clinicians' oral language (because more was used) so they tended to focus on the cognitive and social (specifically the nonverbal dimensions) components of the clinicians' communication. Because of the low language proficiency of the two clients, the majority of the therapy tasks required single word responses or nonverbal responses such as pointing. The single word utterances and short phrases used by the clients (client "Y" was, for the most part, nonverbal) may not have been a problem for the MSJ because the clients' responses were frequently echoic or it was obvious that a correct response was made because of the clinicians' reinforcement. Even with somewhat more verbal bilingual clients, the aspect of "code switching" as part of the normal developmental process of bilingual language learners may facilitate the monolingual-English supervisors'

understanding of the oral language. Therefore, the critical variable in a monolingual supervisor's abilty to understand verbal communication interactions may be the complexity of the oral language and not necessarily the amount. As the complexity nears adult form and with less code switching occuring, the more difficult it is for a monolingual-English supervisor to comprehend the verbal dimensions of client/clinician interaction. Whereas the BSJ had no difficulty understanding the adult forms of the verbal dimensions of the clinicians' communication but had difficulty with the clients' oral communication (because of specific attention to the disordered linguistic aspects) they may have focused on attempting to comprehend or analyze (with limited success) to a greater degree, thus resulting in more "Don't Know, Can't Tell" judgments. Further studies need to be undertaken to provide some clarity to the questions involving how much emphasis needs to be placed on the linguistic components of bilingual language therapy, the effect of the amount (and compexity) of oral language used by clinicans and clients, and the effect of specific tasks on supervisors' judgments.

Data from this study indicate that the MSJ and the BSJ did not differ in their general approach to supervision management decisions. The overwhelmingly predominant supervison strategy which was indicated was to meet with the clinicians to discuss what was happening within specific tasks. If this is the case, the monolingual supervisor can gain information from the clinicians as to questions or doubts about the linguistic aspects of the clients or clinicians and about specific tasks.

In short, the extent to which the linguistic components of communication need to be emphasized in communicative interactions, relative to the cognitive and social components, needs to be examined, as well as the amount of oral language used and the effect of tasks on supervisors' judgments. The emphasis on linguistics in bilingual language therapy may not be significantly different from the current thinking about the relative importance of the linguistic

components in English communicative competence, that is, that in many instances with handicapped communicators, the overall communicative effect is more important than the discrete parts.

SUPERVISION ISSUES

Results of the present study strongly confirm that the conference is a critical component in the supervisory process and that written feedback in bilingual therapy situations would be used less frequently. All the supervisor-judges chose some dimension of the conference as being the predominant supervision management strategy to use to make case management decisions. Therefore, the conference process must be detailed in theory and training in any courses pertaining to supervision in speech-language pathology and audiology.

Two unique aspects of the supervision program at New Mexico State University (NMSU) are that it has as dominant foci developing the knowledge and skill of the supervisors' communicative competence and critical observation. With these foci it has been possible to emphasize the importance of the linguistic, cognitive, and social (and therefore nonverbal and cultural) dimensions of communication in a bilingual/bicultural community. It may be through this specific training in the supervisory process that the monolingual supervisors developed an awareness and sensitivity to the cognitive, linguistic, and social components of communication that bridges the gap between languages and cultures. A supervisor must certainly have the awareness and sensitivity to linguistic and cultural differences in order to know what questions need to be asked or what comments need to made in conferences. To test the hypothesis that bilingual/bicultural sensitivity training and critical skill training in supervision does make a difference, however, additional study would need to be done. One study could involve the same bilingual and monolingual supervisors judging therapy done in English, rather than Spanish. Such a study would serve as a control for the present study and perhaps add some infomation needed to

understand the extent to which training in the supervisory process affects judgments made about the cognitive, linguistic, and social components of communication. Another project could involve bilingual and monolingual supervisor-judges who had not been trained, or who had been trained in a setting (or settings) different from where the present study was conducted.

If the Bilingual Supervision Judging Form is to be used as a research instrument in a more extensive investigation changes need to be made and validity and reliabiity studies should be done. The form in its present format does not separate the various aspects of linguistics (phonologic, semantic, syntactic). With more discrete analysis, patterns of differences between bilingual and monolingual supervisors might emerge. For example, monolingual-English supervisors might not be able to accurately judge the subtle allophonic (stops and fricatives) differences for the phoneme /b/ in Spanish in connected discourse, but can judge accuracy based on clinician reinforcement in an articulation drill. Additionally, the effects of dialectal differences in semantics and syntax on monolingual-English supervisors' judgments need to be investigated and the BSJF would need to be revised to account for those specific variables as individual entities.

In summary, no simple answer exists to the question of whether bilingual supervision makes a difference. As demonstrated by the present research, the question can be addressed, examined, and discussed from two vantage points: bilingual issues or ssupervision issues. The present study was instrumental in providing initial data for review which in turn raised additional questions to be studied. Currently, bilingualism and supervision in Communicative Disorders both provide challenging issues and questions to the profession. The data from the national census reported in the introduction to this paper emphasize the necessity for efforts to learn about and deal with minority communicators in today's society. Presently the area of clinical supervision is enjoying a surge

of energy to establish its importance within the profession. Therefore, it is imperative that additional inquiries be made into the multidimensional domains of these two topics. The combined area of bilingual supervision appears to be fruitful for future research activity.

BILINGUAL SUPERVISION JUDGING FORM

CLIENT:_____ SEGMENT #:_____ JUDGE:_____

TERMINAL BEHAVIOR:_____

TASK:_____

****

CODE: 1 = Poor, Failing, Not acceptable
2 = Weak, Marginal, Below average
3 = Satisfactory, Average, Acceptable
4 = Very good, Above average
5 = Exceptional, Excellent, Superior
NA = Not Applicable
DK = Don't know, Can't tell

****

I THE CLINICIAN(S):

1. Was confident	1	2	3	4	5	NA	DK
2. Was attentive	1	2	3	4	5	NA	DK
3. Was comfortable	1	2	3	4	5	NA	DK
4. Was comprehending the client	1	2	3	4	5	NA	DK
5. Was enthusiastic	1	2	3	4	5	NA	DK
6. Was enjoying the task	1	2	3	4	5	NA	DK
7. Was the dominant person	1	2	3	4	5	NA	DK
8. Was the non-dominant person	1	2	3	4	5	NA	DK
9. Was an equal participant	1	2	3	4	5	NA	DK
10. Responded to verbal cues	1	2	3	4	5	NA	DK
11. Responded to nonverbal cues	1	2	3	4	5	NA	DK

12. Used approp. positioning	1	2	3	4	5	NA	DK
13. Used verbal reinforcement	1	2	3	4	5	NA	DK
14. Used nonverbal reinforcement	1	2	3	4	5	NA	DK
15. Used NV to facil. comprehen.	1	2	3	4	5	NA	DK
16. Judged responses accurately	1	2	3	4	5	NA	DK
17. Reacted approp. to client's communication attempts	1	2	3	4	5	NA	DK
18. Recorded data	1	2	3	4	5	NA	DK
19. Used materials approp. to clients's needs/interests	1	2	3	4	5	NA	DK
20. Used materials approp. to task	1	2	3	4	5	NA	DK
21. Managed behavior approp.	1	2	3	4	5	NA	DK
22. Served as an approp. communication model	1	2	3	4	5	NA	DK
23. Used approp. remedial methodology	1	2	3	4	5	NA	DK
24. Modifies inapprop. behavior in self	1	2	3	4	5	NA	DK
25. Used approp. pace	1	2	3	4	5	NA	DK
26. Used time efficiently	1	2	3	4	5	NA	DK

****

CODE: 1 = Never
2 = Less than 1/2 the time
3 = Approximately 1/2 the time
4 = More than 1/2 the time
5 = Always
NA = Not applicable
DK = Don't know, Can't tell

****

II THE CLIENT:

27. Was confident	1	2	3	4	5	NA	DK
28. Was attentive	1	2	3	4	5	NA	DK
29. Was comfortable	1	2	3	4	5	NA	DK
30. Was enthusiastic	1	2	3	4	5	NA	DK
31. Was comprehending	1	2	3	4	5	NA	DK
32. Was enjoying task	1	2	3	4	5	NA	DK
33. Was the dominant person	1	2	3	4	5	NA	DK
34. Was the non-dominant person	1	2	3	4	5	NA	DK
35. Was an equal partner	1	2	3	4	5	NA	DK
36. Initiated interaction	1	2	3	4	5	NA	DK
37. Demonstrated turn-taking	1	2	3	4	5	NA	DK
38. Responded to verbal cues	1	2	3	4	5	NA	DK
39. Responded to nonverbal cues	1	2	3	4	5	NA	DK
40. Responded to verbal reinforcement	1	2	3	4	5	NA	DK
41. Responded to nonverbal reinforcement	1	2	3	4	5	NA	DK
42. Produced correct responses	1	2	3	4	5	NA	DK
43. Was cooperative	1	2	3	4	5	NA	DK
44. Exhibited off-task behavior	1	2	3	4	5	NA	DK

45. Demonstrated age-appropriate cognitive development	1	2	3	4	5	NA	DK
46. Demonstrated age-appropriate social development	1	2	3	4	5	NA	DK
47. Demonstrated appropriate conversational skills	1	2	3	4	5	NA	DK
48. Demonstrated age-appropriate linguistic skills	1	2	3	4	5	NA	DK
49. Demonstrated age-appropriate articulation skills	1	2	3	4	5	NA	DK
50. Demonstrated age-appropriate motor skills	1	2	3	4	5	NA	DK
51. Demonstrated a variety of language functions (e.g., heuristic, informative, personal, interactional, performative)	1	2	3	4	5	NA	DK

Based on your judgments of the present task, what would be your next step in the supervisory process:

_____1. Meet with the clinicians to:

_____a. Get more information from the clinicians about the task.

_____b. Discuss continuing the task as it is set up to attain a specific objective.

_____c. Discuss continuing the task but with modifications (specify).

_____d. Discuss discontinuing the task.

_____e. Other (specify)

_____2. Provide written feedback to the clinicians suggesting:

_____a. That the clinicians provide the supervisor with more information through written form.

_____b. Continuing the task as it is set up.

_____c. Continuing the task but with modifications (specify).

_____d. Discontinuing the task.

_____e. Other (specify)

_____3. Do demonstration therapy

_____4. Do nothing

_____5. Other (specify)